



**Department of Veterans Affairs  
Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 15-00604-488**

**Combined Assessment Program  
Review of the  
VA Pittsburgh Healthcare System  
Pittsburgh, Pennsylvania**

**August 26, 2015**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**

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## Glossary

AD	advance directive
CAP	Combined Assessment Program
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA Pittsburgh Healthcare System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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## Executive Summary

**Review Purpose:** The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of June 15, 2015.

**Review Results:** The review covered eight activities. We made no recommendations in the following three activities:

- Coordination of Care
- Computed Tomography Radiation Monitoring
- Advance Directives

The facility's reported accomplishments were receiving the American Heart Association/American Stroke Association gold award and the Fine Awards Teamwork Excellence in Health Care platinum award from the Jewish Healthcare Foundation in partnership with The Fine Foundation.

**Recommendations:** We made recommendations in the following five activities:

*Quality Management:* Ensure that licensed independent practitioners who perform emergency airway management have the appropriate skills and training.

*Environment of Care:* Document evacuation sled training in the Talent Management System.

*Medication Management:* Revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users.

*Surgical Complexity:* Ensure post-anesthesia care competency assessment is completed for critical care nurses on the intensive care units.

*Emergency Airway Management:* Ensure that clinician reassessment for continued emergency airway management competency includes review of clinician-specific data and all required elements.

## Comments

The Interim Veterans Integrated Service Network Director and Acting Facility Director concurred with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 23–28, for the full text of the Directors' comments.) We consider recommendation 3 closed and will follow up on the planned actions for the open recommendations until they are completed.



JOHN D. DAIGH, JR., M.D.  
Assistant Inspector General for  
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## Objectives and Scope

### Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

### Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Surgical Complexity
- EAM

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2014 and FY 2015 through June 15, 2015, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania, Report No. 12-03746-161, May 2, 2013*).

During this review, we presented crime awareness briefings for 563 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. We distributed an electronic survey to all facility employees and received 681 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

## Reported Accomplishments

### **American Heart Association/American Stroke Association Award**

The facility earned the American Heart Association/American Stroke Association gold award for the fourth year in a row. This award recognizes medical centers that demonstrate at least 85 percent compliance for 2 years in each of the association's five heart failure achievement measures.

### **Fine Awards Teamwork Excellence in Health Care Award**

The facility earned the Fine Awards Teamwork Excellence in Health Care platinum award from the Jewish Healthcare Foundation in partnership with The Fine Foundation. The facility earned this award for its revamped policies and procedures for anesthesia, surgery, and recovery for joint replacement patients. The focus of the award is to encourage teamwork in developing systems, tools, and programs to better serve patients and their families. This is the third time the facility has received the award.

## Results and Recommendations

### QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.<sup>a</sup>

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, 12 credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. <ul style="list-style-type: none"> <li>• The committee routinely reviewed aggregated data.</li> <li>• QM, patient safety, and systems redesign appeared to be integrated.</li> </ul>		
	Peer reviewed deaths met selected requirements: <ul style="list-style-type: none"> <li>• Peers completed reviews within specified timeframes.</li> <li>• The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings.</li> <li>• Involved providers were invited to provide input prior to the final Peer Review Committee determination.</li> </ul>		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	<p>Credentialing and privileging processes met selected requirements:</p> <ul style="list-style-type: none"> <li>• Facility managers reviewed privilege forms annually and ensured proper approval of revised forms.</li> <li>• Facility managers ensured appropriate privileges for licensed independent practitioners.</li> <li>• Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation.</li> <li>• Facility managers properly maintained licensed independent practitioners' folders.</li> </ul>	<ul style="list-style-type: none"> <li>• Of the 12 licensed independent practitioners' folders reviewed, 10 practitioners' EAM privileges were not appropriate for their skills and training.</li> </ul>	<p>1. We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate skills and training.</p>
	<p>Observation bed use met selected requirements:</p> <ul style="list-style-type: none"> <li>• The facility gathered data regarding appropriateness of observation bed usage.</li> <li>• The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.</li> </ul>		
	<p>The process to review resuscitation events met selected requirements:</p> <ul style="list-style-type: none"> <li>• An interdisciplinary committee reviewed episodes of care where resuscitation was attempted.</li> <li>• Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code.</li> <li>• The facility collected data that measured performance in responding to events.</li> </ul>		

NM	Areas Reviewed (continued)	Findings	Recommendations
	<p>The surgical review process met selected requirements:</p> <ul style="list-style-type: none"> <li>• An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes.</li> <li>• The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement.</li> <li>• The Surgical Work Group reviewed additional data elements.</li> </ul>		
	<p>Clinicians appropriately reported critical incidents.</p>		
	<p>The safe patient handling program met selected requirements:</p> <ul style="list-style-type: none"> <li>• A committee provided program oversight.</li> <li>• The committee gathered, tracked, and shared patient handling injury data.</li> </ul>		
	<p>The process to review the quality of entries in the EHR met selected requirements:</p> <ul style="list-style-type: none"> <li>• A committee reviewed EHR quality.</li> <li>• A committee analyzed data at least quarterly.</li> <li>• Reviews included data from most services and program areas.</li> </ul>		
	<p>The policy for scanning internal forms into EHRs included the following required items:</p> <ul style="list-style-type: none"> <li>• Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate.</li> <li>• A correction process if scanned items have errors.</li> </ul>		

NM	Areas Reviewed (continued)	Findings	Recommendations
	<ul style="list-style-type: none"> <li>A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.</li> </ul>		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

## EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in emergency management.<sup>b</sup>

At the Henry John Heinz campus, we inspected the primary care clinics and the community living center (dementia specialty care, long-term care, and hospice units). At the University Drive campus, we inspected the intensive care units (3A, 3E, and 4E), the 5E stepdown unit, 4W medicine, 5W surgery, the Rainbow clinic, the vascular laboratory, the primary care clinics, the women's health clinic, the 3CB chronic locked MH unit, the 4CB acute MH locked unit, and the Emergency Department. Additionally, we reviewed relevant documents, including 10 employee training and competency records, and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	<b>Areas Reviewed for SCI Center</b>		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
NA	The facility met fire safety requirements in the SCI Center.		
NA	The facility met environmental safety requirements in the SCI Center.		
NA	The facility met infection prevention requirements in the SCI Center.		
NA	The facility met medication safety and security requirements in the SCI Center.		
NA	The facility met patient privacy requirements in the SCI Center.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	<b>Areas Reviewed for Emergency Management</b>		
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		
	The facility maintained a list of resources and assets it may need during an emergency.		

NM	Areas Reviewed for Emergency Management (continued)	Findings	Recommendations
	The facility had a written Emergency Operations Plan that addressed key components.		
	The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time.		
	Employees received training and competency assessment on use of emergency evacuation devices.		
	Evacuation devices were immediately accessible and in good repair.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	<p>Local policy on the facility fire plan reviewed, which required documentation of evacuation sled training by the trainer and the employee's supervisor in the Talent Management System.</p> <ul style="list-style-type: none"> <li>Evacuation sled training was documented in records maintained by supervisors rather than being documented in the Talent Management System.</li> </ul>	<p>2. We recommended that the facility document evacuation sled training in the Talent Management System.</p>
<b>Areas Reviewed for Construction Safety</b>			
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

## Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.<sup>c</sup>

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the 4W medicine and 5W surgery units, community living center, Emergency Department, and intensive care units (3A, 3E, and 4E) and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
NA	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
	The facility conducted and documented inspections of all medication storage areas at least monthly, fully implemented corrective actions, and monitored the changes.		
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	<ul style="list-style-type: none"> <li>Facility policy for safe use of automated dispensing machines did not include employee training and minimum competency requirements for users.</li> </ul>	<p><b>3.</b> We recommended that the facility revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users and that facility managers monitor compliance.</p>
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

## Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.<sup>d</sup>

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 45 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: <ul style="list-style-type: none"> <li>• Provide training in the use of the computerized consult package</li> <li>• Review and manage consults</li> </ul>		
	Consult requests met selected requirements: <ul style="list-style-type: none"> <li>• Requestors included the reason for the consult.</li> <li>• Requestors selected the proper consult title.</li> <li>• Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.</li> </ul>		
	The facility met any additional elements required by VHA or local policy.		

## CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.<sup>e</sup>

We reviewed relevant documents, including qualifications and dosimetry monitoring for six CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 49 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: <ul style="list-style-type: none"> <li>• A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance</li> <li>• CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer</li> <li>• A process for managing/reviewing CT protocols and procedures to follow when revising protocols</li> <li>• Radiologist review of appropriateness of CT orders and specification of protocol prior to scans</li> </ul>		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

## ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.<sup>f</sup>

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 50 randomly selected patients who had an acute care admission January 1–December 31, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had an AD policy that addressed: <ul style="list-style-type: none"> <li>• AD notification, screening, and discussions</li> <li>• Proper use of AD note titles</li> </ul>		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. <ul style="list-style-type: none"> <li>• Employees correctly posted patients' AD status.</li> </ul>		
	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. <ul style="list-style-type: none"> <li>• When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.</li> </ul>		
	The facility met any additional elements required by VHA or local policy.		

## Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to the assigned surgical complexity designation.<sup>9</sup>

We reviewed relevant documents and the training records of 120 employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
X	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.	<ul style="list-style-type: none"> <li>None of the 30 critical care nurses on the intensive care units had post-anesthesia care competency assessment documentation completed.</li> </ul>	<p><b>4.</b> We recommended that facility managers ensure post-anesthesia care competency assessment is completed for critical care nurses on the intensive care units.</p>
NA	<p>The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation.</p> <ul style="list-style-type: none"> <li>The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.</li> </ul>		
	The facility complied with any additional elements required by VHA or local policy.		

## EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.<sup>h</sup>

We reviewed relevant documents, including competency assessment documentation of 12 clinicians applicable for the review period January 1–June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	Facility policy addressed key VHA requirements, including: <ul style="list-style-type: none"> <li>• Competency assessment and reassessment processes</li> <li>• Use of equipment to confirm proper placement of breathing tubes</li> <li>• A plan for managing a difficult airway</li> </ul>		
	Initial competency assessment for EAM included: <ul style="list-style-type: none"> <li>• Subject matter content elements and completion of a written test</li> <li>• Successful demonstration of procedural skills on airway simulators or mannequins</li> <li>• Successful demonstration of procedural skills on patients</li> </ul>		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	<p>Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included:</p> <ul style="list-style-type: none"> <li>• Review of clinician-specific EAM data</li> <li>• Subject matter content elements and completion of a written test</li> <li>• Successful demonstration of procedural skills on airway simulators or mannequins</li> <li>• At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert</li> <li>• A statement related to EAM if the clinician was not a licensed independent practitioner</li> </ul>	<ul style="list-style-type: none"> <li>• None of the 10 clinicians with reassessments for continued EAM competency had clinician-specific EAM data reviewed.</li> <li>• Of the 10 clinicians with reassessments for continued EAM competency:                             <ul style="list-style-type: none"> <li>○ Eight did not have documentation of all required subject matter content elements and evidence of test completion.</li> <li>○ Seven did not have evidence of successful demonstration of all required procedural skills on airway simulators or mannequins.</li> <li>○ Two did not have evidence of successful airway management and intubation of at least one patient in the preceding 2 years, written certification of airway management competency from the evaluation superior at the non-VA facility, or successful demonstration of airway management and intubation skills to the facility subject matter expert.</li> </ul> </li> </ul>	<p><b>5.</b> We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes review of clinician-specific data and all required elements and that facility managers monitor compliance.</p>
	<p>The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.</p>		
	<p>Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.</p>		
	<p>The facility complied with any additional elements required by VHA or local policy.</p>		

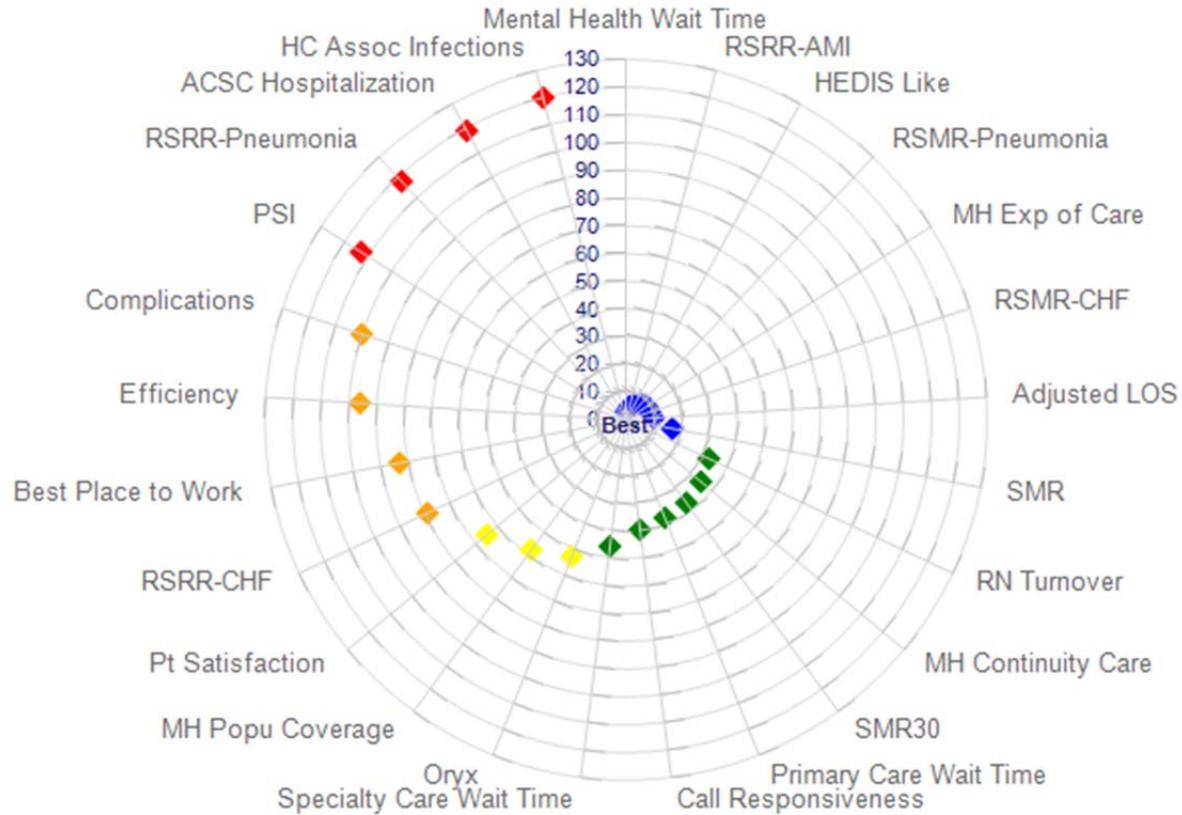
<b>Facility Profile (Pittsburgh/646) FY 2015 through June 2015<sup>1</sup></b>	
<b>Type of Organization</b>	Tertiary
<b>Complexity Level</b>	1a-High complexity
<b>Affiliated/Non-Affiliated</b>	Affiliated
<b>Total Medical Care Budget in Millions</b>	\$543
<b>Number of:</b>	
• <b>Unique Patients</b>	60,630
• <b>Outpatient Visits</b>	664,994
• <b>Unique Employees<sup>2</sup></b>	2,940
<b>Type and Number of Operating Beds (as of May 2015):</b>	
• <b>Hospital</b>	224
• <b>Community Living Center</b>	225
• <b>MH</b>	88
<b>Average Daily Census (as of May 2015):</b>	
• <b>Hospital</b>	163
• <b>Community Living Center</b>	171
• <b>MH</b>	71
<b>Number of Community Based Outpatient Clinics</b>	6
<b>Location(s)/Station Number(s)</b>	Pittsburgh/646A4 St. Clairsville/646GA Greensburg/646GB Monaca/646GC Washington/646GD Uniontown/646GE
<b>VISN Number</b>	4

<sup>1</sup> All data is for FY 2015 through June 2015 except where noted.

<sup>2</sup> Unique employees involved in direct medical care (cost center 8200).

### Strategic Analytics for Improvement and Learning (SAIL)<sup>3</sup>

Pittsburgh VAMC - 4-Star in Quality (FY2015Q1) (Metric)

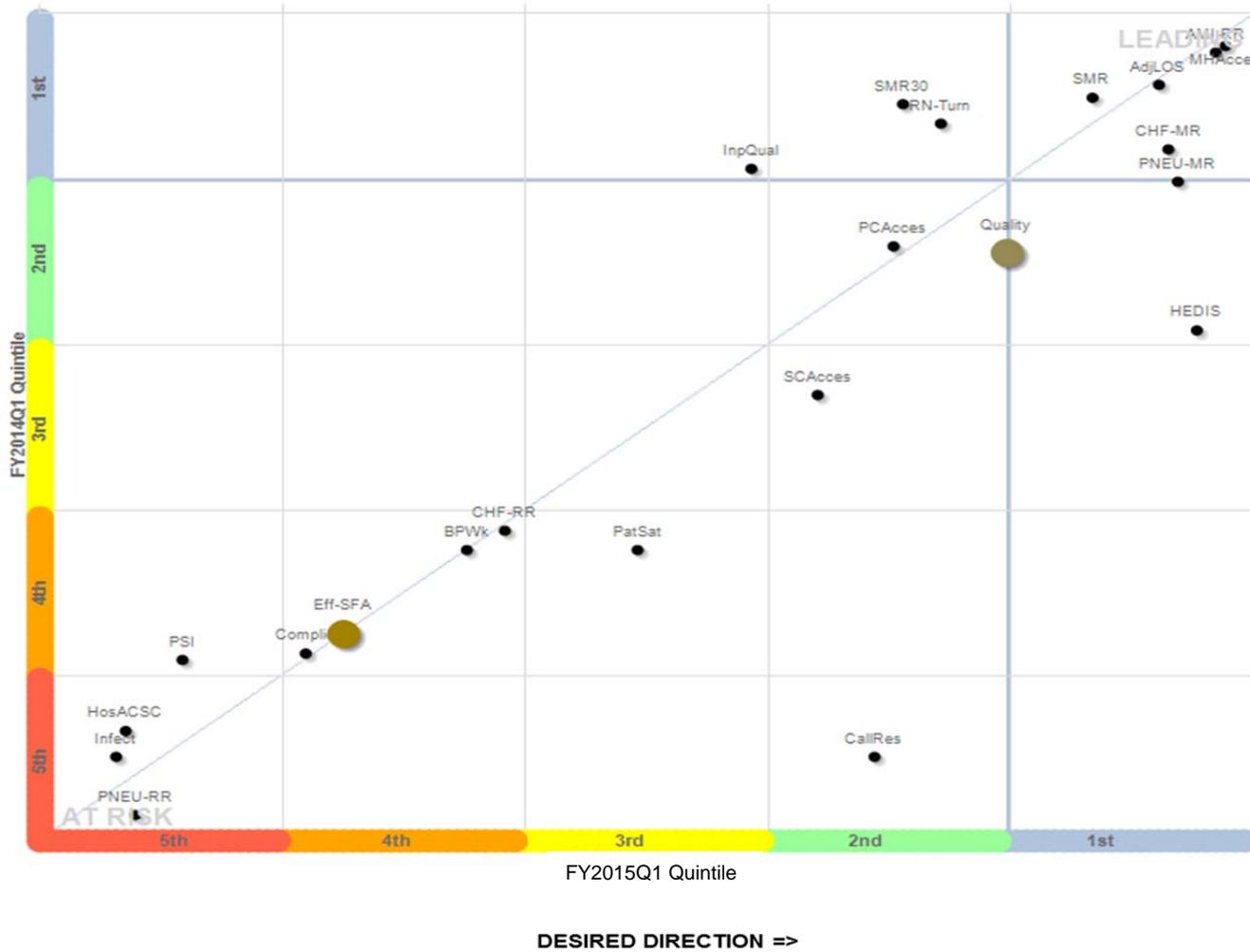


Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

<sup>3</sup> Metric definitions follow the graphs.

## Scatter Chart

FY2015Q1 Change in Quintiles from FY2014Q1



**NOTE**

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

DESIRED DIRECTION ==>

DESIRED DIRECTION ==>

## Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

## Interim VISN Director Comments

**Department of  
Veterans Affairs**

# Memorandum

**Date:** July 22, 2015

**From:** Interim Director, VA Healthcare – VISN 4 (10N4)

**Subject: CAP Review of the VA Pittsburgh Healthcare System,  
Pittsburgh, PA**

**To:** Acting Director, Washington, DC, Office of Healthcare Inspections  
(54DC)

Director, Management Review Service (VHA 10AR MRS OIG CAP  
CBOC)

1. I have reviewed the response provided by the VA Pittsburgh Healthcare System and I am submitting to your office as requested. I concur with all responses.

2. If you have any questions or require additional information, please contact Moira Hughes, VISN 4 Quality Management Officer at 412-822-3294.

*(original signed by:)*  
Carla Sivek

Attachment

## Acting Facility Director Comments

**Department of  
Veterans Affairs**

# Memorandum

**Date:** July 20, 2015

**From:** Acting Director, VA Pittsburgh Healthcare System (646/00)

**Subject: CAP Review of the VA Pittsburgh Healthcare System,  
Pittsburgh, PA**

**To:** Interim Director, VA Healthcare – VISN 4 (10N4)

1. The findings from the VA Pittsburgh Healthcare System Combined Assessment Program (CAP) reviewed by the Office of Inspector (OIG) conducted June 15, to June 19, 2015 have been reviewed.

2. Attached are the facility responses addressing each recommendation, including actions that are in progress and those that have already been completed.

*(original signed by:)*

BARBARA FORSHA, MSN, RN, CPPS, ET  
Acting Director

## Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

### **OIG Recommendations**

**Recommendation 1.** We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate skills and training.

Concur

Target date for completion: January 31, 2016

Facility response: Out of OR Airway Management is performed by critical care medicine fellows, pulmonary medicine fellows and attending physicians who are board certified in Critical Care Medicine, Pulmonary Critical Care Medicine and Emergency Medicine. Attending Physicians directly supervise or personally perform all out of OR intubations at this institution. Intubations are predominantly performed using video laryngoscopy. The procedure itself is recorded in the medical record using an "Endotracheal Intubation" note template. Physicians are required to maintain a log of all intubations that they perform and to report such procedures at the time of re-credentialing. The current requirement is 4 live intubations in 2 years.

All intubations are reviewed on a monthly basis by the Director of the Out-of-OR Airway Program, and any issues are reported to the Medical Director of Anesthesia. Discussion with, and/or peer review of providers is conducted as indicated. All physicians and fellows have access to Anesthesiology OR suites to refresh their skills or for additional training as recommended by the Medical Director of Anesthesiology or the Out-of-OR Airway Program Director.

Each physician with a privilege for airway management is required to complete OORAM Part 1 and 2 every two years as part of their re-credentialing or initial credentialing (new hires). If a physician does not maintain OORAM and perform a minimum of 4 live intubations in a period of 2 years, then his or her intubation privileges will not be renewed at the time of re-credentialing. New hires must provide a certificate of airway competence from their prior institution or training program but are also required to complete OORAM training before being granted intubation privileges. Focused Practice Performance Evaluations (FPPE) of new physicians will include a demonstration of intubation skills in the Operating Room to the Medical Director of Anesthesia or his designee using video laryngoscopy for two live patients.

Physicians found to be non-compliant during the review were from Critical Care, Pulmonary Medicine, and, Emergency Department. To date, all physicians from Critical Care and Pulmonary are now compliant. VA Pittsburgh Healthcare System's Medical Executive Board will consider the following proposal for concurrence at its August 26<sup>th</sup> meeting:

"The existing privilege of "Emergency Airway Management" will expire not later than November 30, 2015 for any current provider who has not completed required VA training within the two year period ending November 30, 2015. Such training consists of Out-of-Operating Room Airway Management Training in VA's TMS, Simulation training, and demonstration of videolaryngoscopic intubations consistent with revised Medical Center Memorandum TX-157, Emergency Airway Management." If the proposal to Medical Executive Board is approved, in the absence of completed training, the current privilege for Emergency Airway Management will expire for those providers.

**Recommendation 2.** We recommended that the facility document evacuation sled training in the Talent Management System.

Concur

Target date for completion: August 7, 2015

Facility response: Education will build an item in TMS for the recording of evacuation sled training. Supervisors and sled trainers will give sign-in sheets to their service line TMS administrators to document training completion within TMS.

**Recommendation 3.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users and that facility managers monitor compliance.

Concur

Target date for completion: July 15, 2015

Facility response: Effective July 15, 2015, the policy/procedure TX-009 was updated and posted on SharePoint with the following: All Omni cell users are required to complete Omnicell training during orientation and then validate competency annually. Omnicell training for nursing staff will include at a minimum the following: adding patient names to Omnicell system if needed, dispensing medication, returning and/or wasting medication, witnessing controlled substance medication restock, monitoring and resolving discrepancies, and conducting inventory count and controlled substance inspections. Omnicell training for pharmacy staff will include at a minimum the following: generating restock reports, restocking the Omnicell cabinets, generating transaction reports, and addressing and resolving discrepancies. Supervisors may request access codes for new personnel after they have completed the Omnicell training.

**Recommendation 4.** We recommended that facility managers ensure post-anesthesia care competency assessment is completed for critical care nurses on the intensive care units.

Concur

Target date for completion: September 1, 2015

Facility response: Under the direction of the Critical Care nurse educators designated Post Recovery Anesthesia Unit (PACU) registered nurses will present post-anesthesia care content and complete competencies for the Critical Care registered nurses who participate in post-anesthesia patient recovery. Competency assessment will be specific to the appropriate level of care provided by the SICU vs Stepdown areas. Completed competency checklists for post-anesthesia care will be maintained by the Critical Care educators for each Critical Care registered nurse. Post-anesthesia care competency will be incorporated in all Critical Care Courses and Critical Care orientations for newly hired registered nurses. Critical Care educators will monitor any recurring problem areas in the competency validation process to determine if additional education is warranted.

**Recommendation 5.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes review of clinician-specific data and all required elements and that facility managers monitor compliance.

Concur

Target date for completion: January 31, 2016

Facility response: All Out-of-OR intubations are reviewed on a monthly basis, and airway complications are discussed at the CPR committee and with the Medical Director of Anesthesia. Select cases are peer-reviewed as indicated. Further training may be recommended. Clinician-specific data are now maintained on a new electronic posting via SharePoint and include the number of intubations performed, complications, OORAM certifications and credentialing details for each privileged provider. In the current absence of external or national VHA benchmarks for performance, physicians will be compared within the current group at VAPHS.

Physicians found to be non-compliant during the review were from Critical Care, Pulmonary Medicine, and, Emergency Department. To date, all physicians from Critical Care and Pulmonary are now compliant. VA Pittsburgh Healthcare System's Medical Executive Board will consider the following proposal for concurrence at its August 26<sup>th</sup> meeting: "The existing privilege of "Emergency Airway Management" will expire not later than November 30, 2015 for any current provider who has not completed required VA training within the two year period ending November 30, 2015. Such training consists of

Out-of-Operating Room Airway Management Training in VA's TMS, Simulation training, and demonstration of videolaryngoscopic intubations consistent with revised Medical Center Memorandum TX-157, Emergency Airway Management." If the proposal to Medical Executive Board is approved, in the absence of completed training, the current privilege for Emergency Airway Management will expire for those providers.

## Office of Inspector General Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the OIG at (202) 461-4720.
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## **Report Distribution**

### **VA Distribution**

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U.S. Senate: Robert P. Casey, Jr.; Patrick J. Toomey  
U.S. House of Representatives: Mike Doyle, Mike Kelly, Tim Murphy, Keith Rothfus,  
Bill Shuster

This report is available at [www.va.gov/oig](http://www.va.gov/oig).

## Endnotes

<sup>a</sup> References used for this topic included:

- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

<sup>b</sup> References used for this topic included:

- VHA Directive 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, “Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection,” Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

<sup>c</sup> References used for this topic included:

- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

<sup>d</sup> The reference used for this topic was:

- Under Secretary for Health, “Consult Business Rule Implementation,” memorandum, May 23, 2013.

<sup>e</sup> References used for this topic included:

- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, “Radiation risks of diagnostic imaging,” Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, “Online Guide,” updated October 4, 2011.
- The American College of Radiology, “ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT,” Revised 2012.

<sup>f</sup> The references used for this topic included:

- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

<sup>g</sup> References used for this topic included:

- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

<sup>h</sup> References used for this topic included:

- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.